AMENDED IN SENATE JUNE 21, 2000

AMENDED IN ASSEMBLY MAY 28, 1999

AMENDED IN ASSEMBLY APRIL 15, 1999

AMENDED IN ASSEMBLY APRIL 5, 1999

CALIFORNIA LEGISLATURE—1999–2000 REGULAR SESSION

ASSEMBLY BILL No. 93

Introduced by Assembly Members Cedillo, Gallegos, and Villaraigosa
(Principal coauthors: Assembly Members Firebaugh and Wildman)

December 10, 1998

~~An act to amend Sections 12693, 12693.02, 12693.03, 12693.12, 12693.13, 12693.14, 12693.20, 12693.21, 12693.25, 12693.26, 12693.27, 12693.31, 12693.32, 12693.33, 12693.34, 12693.36, 12693.365, 12693.37, 12693.38, 12693.39, 12693.40, 12693.42, 12693.44, 12693.45, 12563.48, 12693.49, 12693.51, 12693.52, 12693.53, 12693.54, 12693.60, 12693.61, 12693.615, 12693.68, and 12693.75 of, to add Sections 12693.41 and 12693.43 to, to repeal Sections 12693.41, 12693.43, and 12693.46 of, and to repeal Chapter 6 (commencing with Section 12693.63) and Chapter 7 (commencing with Section 12693.65) of Part 6.2 of Division 2 of, the Insurance~~ *An act to add Section 12693.755 to the Insurance Code, and to amend Sections 14011.15 and 14012 of the Welfare and Institutions* Code, relating to health.

LEGISLATIVE COUNSEL'S DIGEST

AB 93, as amended, Cedillo. Children: Healthy Families Program: *Medi-Cal Program:* eligibility.

Existing law establishes the Healthy Families Program *administered by the Managed Risk Medical Insurance Board* to arrange for the provision of health, dental, and vision services to eligible children pursuant to a federal program, entitled the State Children's Health Insurance Program. Under existing law, in order to be eligible, an applicant must be applying on behalf of a child, who meets certain requirements, including being in a family having a gross annual household income equal to or less than 200% of the federal poverty level, and meeting the citizenship and immigration status requirements established by federal law. ~~Under existing law the program is administered by the Managed Risk Medical Insurance Board. Under existing law, the level of health benefits for program subscribers is required to be equivalent to those provided to state employees through the Public Employee's Retirement System as of January 1, 1998, except as specified. Existing law also requires the board to determine the coverage for health, dental, and vision benefits, and the copayments for health, dental, and vision benefits, and places a maximum family contribution level for health benefits at $250 per family.~~ Existing law provides for the federal medicaid program, administered by each state, California's version of which is the Medi-Cal program. The Medi-Cal program, which is administered by the State Department of Health Services, provides qualified low-income persons with health care services.

~~This bill would revise the Healthy Families Program to include coverage provided by federal medicaid program, to provide coverage to families that have a gross annual household income equal to or less than 300% of the federal poverty level. The bill would provide for the joint administration of the program by the board and the department and would require the department and the board, to the extent feasible and permissible under federal law and with receipt of necessary federal approval, to develop a simplified program application and enrollment form for applicants that could be submitted by mail. The bill would~~

~~provide for a presumption of eligibility for any individual who is 19 years of age or younger.~~

~~The bill would repeal specified family contribution provisions and instead would require family contributions and copayments to the extent permitted under the federal medicaid program and the federal State Children's Health Insurance Program. The bill would require total annual health, vision, and dental copayments charged to subscribers not exceed $250 per family, and would repeal the provisions requiring the board to establish coverage and copayments for dental and vision benefits. The bill would require coverage for subscribers to meet the federal coverage requirements of the federal medicaid program and the federal State Children's Health Insurance Program, as specified, and would require the coverages to be consistent with the benefits under the state's Medi-Cal program, as specified.~~

Existing law continuously appropriates money from the Healthy Families Fund for purposes of implementation of the Healthy Families Program.

~~This~~

The bill would provide that any child enrolled in specified programs shall be deemed to have met the income eligibility requirements for the Healthy Families Program and the Medi-Cal program. This bill would provide that~~— its~~ *this* ~~provisions —~~ *provision* shall *not* be ~~inoperative —~~ *implemented* in any fiscal year in which funds have not been specifically designated in the Budget Act for that fiscal year for implementation of ~~this bill~~ *that provision*.

Existing law requires certain Medi-Cal recipients to file annual reaffirmations of eligibility and at other times as specified by the department.

This bill would eliminate the authority of the department to require additional reaffirmations of eligibility and would, commencing January 1, 2001, require the department to eliminate quarterly status reports.

Because each county is responsible for Medi-Cal eligibility determinations, and because this bill would expand Medi-Cal eligibility, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed $1,000,000 statewide and other procedures for claims whose statewide costs exceed $1,000,000.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: ~~no~~ *yes*.

The people of the State of California do enact as follows:

~~SECTION 1. Section 12693 of the Insurance Code is amended to read:~~

~~12693. The Legislature declares all of the following:~~

~~(a) Approximately 1.85 million California children, 17 percent of children ages 17 and under, have no health insurance. One in four California children, which is 2.3 million, rely on Medi-Cal for insurance coverage, while just over half of the state's children, 53 percent, have employer-based coverage through a parent.~~

~~(b) Most uninsured California children (2.3 million) come from low-income families, with incomes below 300 percent of the federal poverty level. Many of their parents are also uninsured (645,000). Many of these low-income families make too much money to generally qualify for free Medi-Cal. Many are employed in working class jobs that typically do not offer insurance and they cannot afford private health insurance, or they qualify for health care programs but do not enroll for reasons that include unnecessarily complex and burdensome application and eligibility requirements.~~

~~(c) Lack of health insurance has serious consequences for those families without coverage.~~

~~(d) Notwithstanding the generally good health of children, health insurance coverage is important to~~

~~ensure that they receive the health care that is essential to monitor their growth, nutrition, and development and to address potential health problems early.~~

~~(e) Lack of insurance coverage for children results in reduced access to medical services, resulting in restricted access to primary and preventive care and increased reliance on emergency rooms and hospitals for treatment. Timely treatment for infectious and chronic diseases can prevent more serious medical conditions in children of all ages.~~

~~(f) When a child is seriously ill or injured, the costs of needed medical care can force families into financial ruin.~~

~~(g) That by July 1, 2000, there shall be in place a program providing access to health coverage to all children residing in households with family incomes below 300 percent of the federal poverty level.~~

~~(h) It is the intent of the Legislature that the program comply with the requirements of Title XXI of the Social Security Act, also know as the State Children's Health Insurance Program and Title XIX of the Social Security Act.~~

~~(i) It is further the intent of the Legislature to do all of the following:~~

~~(1) Establish a health coverage program that ensures comprehensive health care benefits and an easy application and eligibility process for families with gross income of no more than 300 percent of the federal poverty level.~~

~~(2) Maximize federal financial participation by complying with the requirements of Titles XIX and XXI of the Social Security Act (42 U.S.C. Sec. 1396 and following; Sec. 1397aa and following) in administering this program.~~

~~(3) Make implementation of these provisions contingent upon federal approval.~~

~~SEC. 2. Section 12693.02 of the Insurance Code is amended to read:~~

~~12693.02. "Applicant" means a person who is a natural or adoptive parent; a legal guardian; or a caretaker relative, foster parent, or stepparent, who applies for~~

~~coverage under the program on behalf of his or her family or a child or children in the family. ''Applicant'' also means a person 18 years of age who is applying on his or her own behalf or a pregnant woman who is applying on her own behalf for coverage under the program.~~

~~SEC. 3. Section 12693.03 of the Insurance Code is amended to read:~~

~~12693.03. (a) ''Board'' means the Managed Risk Medical Insurance Board.~~

~~(b) ''Department'' means the State Department of Health Services.~~

~~SEC. 4. Section 12693.12 of the Insurance Code is amended to read:~~

~~12693.12. ''Program'' means the Healthy Families Program, which includes a purchasing pool providing health coverage for families without access to affordable employer-based coverage, and a purchasing credit mechanism through which families with access to employer-based dependent coverage can receive financial assistance with the cost of dependent coverage for children.~~

~~SEC. 5. Section 12693.13 of the Insurance Code is amended to read:~~

~~12693.13. ''Purchasing credit member'' means an applicant who is eligible for, and participates in, the purchasing credit component of the program.~~

~~SEC. 6. Section 12693.14 of the Insurance Code is amended to read:~~

~~12693.14. ''Subscriber'' means an applicant who is eligible for, and participates in, the purchasing pool component of the program.~~

~~SEC. 7. Section 12693.20 of the Insurance Code is amended to read:~~

~~12693.20. The Healthy Families Program is hereby created and shall be administered by the department and the Managed Risk Medical Insurance Board.~~

~~SEC. 8. Section 12693.21 of the Insurance Code is amended to read:~~

~~12693.21. The department and the board may do all of the following consistent with the standards in this part~~

~~and the program established pursuant to Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code:~~

~~(a) Determine eligibility criteria for the program.~~

~~(b) Determine the participation requirements of applicants, subscribers, purchasing credit members, and participating health, dental, and vision plans.~~

~~(c) Determine when subscribers' coverage begins and the extent and scope of coverage to the extent authorized under federal law.~~

~~(d) Determine family contribution amount schedules and collect the contributions.~~

~~(e) Provide or make available subsidized coverage through participating health, dental, and vision plans, in a purchasing pool, which may include the use of a purchasing credit mechanism, through supplemental coverage, or through coordination with other state programs.~~

~~(f) Provide for the processing of applications, the enrollment of subscribers, and the distribution of purchasing credits.~~

~~(g) Approve those health plans eligible to receive purchasing credits.~~

~~(h) Enter into contracts.~~

~~(i) Sue and be sued.~~

~~(j) Employ necessary staff.~~

~~(k) Authorize expenditures from the fund to pay program expenses that exceed subscriber contributions, and to administer the program as necessary.~~

~~(*l*) Maintain enrollment and expenditures to ensure that expenditures do not exceed amounts available in the Healthy Families Fund and if sufficient funds are not available to cover the estimated cost of program expenditures, the board shall institute appropriate measures to limit enrollment.~~

~~(m) Issue rules and regulations, as necessary. Until January 1, 2000, any rules and regulations issued pursuant to this subdivision may be adopted as emergency regulations in accordance with the Administrative~~

~~Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, and safety or general welfare. The regulations shall become effective immediately upon filing with the Secretary of State.~~

~~(n) Exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed by this part.~~

~~(o) The department may delegate authority to the board to contract with participating plans or for program administration to the extent authorized under federal law.~~

~~SEC. 9. Section 12693.25 of the Insurance Code is amended to read:~~

~~12693.25. The department and the board may use a purchasing pool model, issuance of purchasing credits, supplemental coverage, or other means as appropriate to meet the purposes of this part.~~

~~SEC. 10. Section 12693.26 of the Insurance Code is amended to read:~~

~~12693.26. The department and the board shall establish a purchasing pool for coverage of program subscribers to enable eligible applicants without access to affordable and comprehensive employer-sponsored coverage to provide their families with health, dental, and vision benefits. The department and the board shall negotiate separate contracts with participating health, dental, and vision plans for each of the benefit packages described in Chapters 5 (commencing with Section 12693.60), 6 (commencing with Section 12693.63), and 7 (commencing with Section 12693.65).~~

~~SEC. 11. Section 12693.27 of the Insurance Code is amended to read:~~

~~12693.27. (a) The department and the board shall develop a purchasing credit mechanism to enable applicants with access to affordable and comprehensive employer-sponsored dependent coverage to have an eligible child enrolled in the employer's health plan.~~

~~Children enrolled in the purchasing credit mechanism may receive dental and vision benefits through the purchasing pool component of the program.~~

~~(b) In order to be eligible for a purchasing credit, the employer shall make a meaningful contribution toward the cost of coverage for an employee's dependents for whom an application is made for a purchasing credit. An employer's contribution, including any increases or decreases in the contribution made after the effective date of this part, may not vary among employees based on wage base or job classification.~~

~~(c) The department and the board shall adopt appropriate mechanisms to recoup purchasing credit expenditures from an employer plan when the employees or dependents on behalf of whose coverage the payments are made are no longer enrolled in that plan.~~

~~(d) An employer utilizing a purchasing credit arrangement and a participating health plan receiving a purchasing credit must use 100 percent of the funds for the purchase of coverage for purchasing credit members including dependent coverage.~~

~~(e) A participating plan shall not assess the department or the board for any portion of late fees, returned checks, or other fees in connection with an employer with group coverage who is also participating in the purchasing credit arrangement.~~

~~(f) An applicant may begin coverage for dependents using a purchasing credit arrangement at any time. Purchasing credit members enrolling in employer-sponsored coverage shall not be considered late enrollees for the purposes of subdivision (d) of Section 1357 and subdivision (b) of Section 1357.50 of the Health and Safety Code, and subdivision (b) of Section 10198.6 and subdivision (*l*) of Section 10700.~~

~~(g) Under no circumstances shall the employee's share of cost, including, deductibles, copayments, and coinsurance, for dependent coverage, including any supplemental coverage necessary to meet the 95 percent actuarial standard established in Section 12693.15 be more~~

than that required as the employee's share of premium if the employee's children were enrolled in the purchasing pool component of the program.

(h) The department and the board may limit participation in the purchasing credit program to those employers that provide employee health benefits through participation in public or private purchasing cooperatives.

SEC. 12. Section 12693.31 of the Insurance Code is amended to read:

12693.31. No participating health, dental, or vision plan shall, in an area served by the program, directly, or through an employee, agent, or contractor, provide an applicant, or a child with any marketing material relating to benefits or rates provided under the program unless the material has been both reviewed and approved by the department and the board.

SEC. 13. Section 12693.32 of the Insurance Code is amended to read:

12693.32. (a) The department and the board may pay designated individuals or organizations an application assistance fee, if the individual or organization assists an applicant to complete the program application, and the applicant is enrolled in the program as a result of the application.

(b) The department and the board may establish the list of eligible individuals, or categories of individuals and organizations, the amount of the application assistance payment and rules necessary to assure the integrity of the payment process.

(c) The department and the board, as part of its community outreach and education campaign, may include community-based face-to-face initiatives to educate potentially eligible applicants about the program and to assist potential applicants in the application process. Those entities undertaking outreach efforts shall not include as part of their responsibilities the selection of a health plan and provider for the applicant. Participating plans shall be prohibited from directly, indirectly, or through their agents conducting in-person,

~~door-to-door, mail, or telephone solicitation of applicants for enrollment except through employers with employees eligible to participate in the purchasing credit mechanism. However, information approved by the department and the board on the providers and plans available to prospective subscribers in their geographic areas shall be distributed through any door-to-door activities for potentially eligible applicants and their children.~~

~~SEC. 14. Section 12693.33 of the Insurance Code is amended to read:~~

~~12693.33. To the extent feasible and permissible under federal law and with receipt of necessary federal approvals, the department and the board shall develop a simplified program application and enrollment form for applicants that may be submitted by mail.~~

~~SEC. 15. Section 12693.34 of the Insurance Code is amended to read:~~

~~12693.34. (a) The department and the board may establish geographic areas within which participating health, dental, and vision plans may offer coverage to subscribers.~~

~~(b) Nothing in this section shall restrict a county organized health system or a local initiative from providing service to program subscribers in their licensed geographic service area.~~

~~SEC. 16. Section 12693.36 of the Insurance Code is amended to read:~~

~~12693.36. (a) Notwithstanding any other provision of law, the department and the board shall not be subject to licensure or regulation by the Department of Insurance or the Department of Corporations, as the case may be.~~

~~(b) Participating health, dental, and vision plans that contract with the program and are regulated by either the Insurance Commissioner or the Department of Corporations shall be licensed and in good standing with their respective licensing agencies. In their application to the program, those entities shall provide assurance of their standing with the appropriate licensing entity.~~

~~(c) Local initiatives that have a contract with the State Department of Health Services, and that contract with the program, and that are licensed by the Department of Corporations but do not have a commercial license from the Department of Corporations, may contract with the department and the board for a maximum of 18 months. During this 18-month period, those plans shall be in good standing with the Department of Corporations and shall demonstrate to the board that they are making a good faith effort to obtain a commercial license with the Department of Corporations. The department and the board may extend this period to 24 months if the department and the board determines the additional time is necessary to comply with this requirement. In their application to the program, those entities shall provide assurance of their standing with the Department of Corporations and shall outline their plans for obtaining commercial licensure.~~

~~(d) County organized health systems and the special health care authority established under Section 101675 of the Health and Safety Code that have a contract with the State Department of Health Services, and that contract with the program, and that are not licensed by either the Insurance Commissioner or the Department of Corporations may contract with the department and the board for a maximum of 24 months. During this 24-month period those plans shall be in good standing with the state agency providing oversight to their operations and shall demonstrate to the board that they are making a good faith effort to obtain licensure with the Department of Insurance or the Department of Corporations. In their application to the program, those entities shall provide assurance of their standing with the appropriate state oversight entity and shall outline their plans for obtaining licensure from the Department of Insurance or the Department of Corporations.~~

~~SEC. 17. Section 12693.365 of the Insurance Code is amended to read:~~

~~12693.365. Geographic managed care plans that have a contract with the department, that contract with the~~

~~program, and that are licensed by the Department of Corporations but do not have a commercial license from the Department of Corporations, may contract with the department and the board for a maximum of 12 months. During this 12-month period, those plans shall be required to be in good standing with the Department of Corporations and shall demonstrate to the department and the board that they are making a good faith effort to obtain a commercial license from the Department of Corporations. In their application to the program, those plans shall provide assurance of their standing with the Department of Corporations and shall outline their plans for obtaining commercial licensure.~~

~~SEC. 18. Section 12693.37 of the Insurance Code is amended to read:~~

~~12693.37. (a) The department and the board shall contract with a broad range of health plans in an area, if available, to ensure that subscribers have a choice from among a reasonable number and types of competing health plans. The board shall develop and make available objective criteria for health plan selection and provide adequate notice of the application process to permit all health plans a reasonable and fair opportunity to participate. The criteria and application process shall allow participating health plans to comply with their state and federal licensing and regulatory obligations, except as otherwise provided in this chapter. Health plan selection shall be based on the criteria developed by the department and the board.~~

~~(b) (1) In its selection of participating plans the department and the board shall take all reasonable steps to assure the range of choices available to each applicant, other than a purchasing credit member, shall include plans that include in their provider networks and have signed contracts with traditional and safety net providers.~~

~~(2) Participating health plans shall be required to submit to the department and the board, on an annual basis, a report summarizing their provider network. The report shall provide, as available, information on the provider network as it relates to:~~

~~(A) Geographic access for the subscribers.~~

~~(B) Linguistic services.~~

~~(C) The ethnic composition of providers.~~

~~(D) The number of subscribers who selected traditional and safety net providers.~~

~~(c) (1) The department and the board shall not rely solely on the Department of Corporations' determination of a health plan network's adequacy or geographic access to providers in the awarding of contracts under this part. The board shall collect and review demographic, census, and other data to provide to prospective local initiatives, health plans, or specialized health plans, as defined in this act, specific provider contracting target areas with significant numbers of uninsured children in low-income families. The board shall give priority to those plans, on a county-by-county basis, that demonstrate that they have included in their prospective plan networks significant numbers of providers in these geographic areas.~~

~~(2) Targeted contracting areas are those ZIP Codes, or groups of ZIP Codes or census tracts or groups of census tracts, that have a percentage of uninsured families greater than the overall percentage of uninsured families in that county.~~

~~(d) In each geographic area, the board shall designate a community provider plan that is the participating health plan which has the highest percentage of traditional and safety net providers in its network. Subscribers selecting such a plan shall be given a family contribution discount as described in Section 12693.43.~~

~~(e) The department and the board shall establish reasonable limits on health plan administrative costs.~~

~~SEC. 19. Section 12693.38 of the Insurance Code is amended to read:~~

~~12693.38. (a) The department and the board shall contract with a sufficient number of dental and vision plans to assure that dental and vision benefits are available to all subscribers. The department and the board shall develop and make available objective criteria for dental and vision plan selection and provide adequate~~

~~notice of the application process to permit all dental and vision plans a reasonable and fair opportunity to participate. The criteria and application process shall allow participating dental and vision plans to comply with their state and federal licensing and regulatory obligations, except as otherwise provided in this part. Dental and vision plan selection shall be based on the criteria developed by the department and the board.~~

~~(b) Participating dental plans shall be required to submit to the department and the board on an annual basis a report summarizing their provider network. The report shall provide, as available, information on the provider network as it relates to each of the following:~~

~~(1) Geographic access for the subscribers.~~

~~(2) Linguistic services.~~

~~(3) The ethnic composition of providers.~~

~~(c) The department and the board shall establish reasonable limits on dental plan administrative costs.~~

~~SEC. 20. Section 12693.39 of the Insurance Code is amended to read:~~

~~12693.39. The department and the board shall establish a process for determining which employer-sponsored health plans are eligible to receive a purchasing credit issued by the program. The process shall assure that the benefits, copayments, coinsurance, and deductibles are no less than 95 percent actuarially equivalent to those provided to program subscribers enrolled in the purchasing pool.~~

~~SEC. 21. Section 12693.40 of the Insurance Code is amended to read:~~

~~12693.40. The department and the board shall contract with health plans to provide coverage supplemental to that provided by an applicant's or applicant's spouse's employer-sponsored health plan for the purchasing credit member, if the employer-sponsored plan's benefits are not 95 percent actuarially equivalent to those provided to subscribers. If supplemental coverage is available and provided, the plan may then, notwithstanding Section 12693.39, become eligible to receive purchasing credits.~~

~~SEC. 22. Section 12693.41 of the Insurance Code is repealed.~~

~~SEC. 23. Section 12693.41 is added to the Insurance Code, to read:~~

~~12693.41. Pursuant to subsection (a) of Section 4912 of the federal Balanced Budget Act of 1997 (P.L. 105-33), any individual who is 19 years of age or younger may be presumed to be eligible in the offices of participating providers during an encounter based on an initial application determination until a formal eligibility determination is made. An application shall be submitted to the independent entity or county, pursuant to Section 12693.75, no later than the last day of the month following the month in which the presumptive determination was made.~~

~~SEC. 24. Section 12693.42 of the Insurance Code is amended to read:~~

~~12693.42. Any purchasing credit issued by the department and the board, or a contractor acting on behalf of the department and the board, pursuant to this part shall have an overall cost to the program no greater than the cost to the program to enroll the subscriber in the lowest cost plan available to the subscriber through the purchasing pool. Administrative costs and the cost to the program of any supplemental product shall be included in the calculation of the cost of the purchasing credit program and deducted from the amount of the purchasing credit.~~

~~SEC. 25. Section 12693.43 of the Insurance Code is repealed.~~

~~SEC. 26. Section 12693.43 is added to the Insurance Code, to read:~~

~~12693.43. To the extent permitted under Titles XIX and XXI of the Social Security Act (42 U.S.C. 1396 and following; 1397aa and following), applicants applying to the purchasing pool shall agree to pay family contributions and copayments.~~

~~SEC. 27. Section 12693.44 of the Insurance Code is amended to read:~~

~~12693.44. (a) The department and the board shall establish family contribution amounts for purchasing credit members that are equivalent to the amounts charged to subscribers participating in the purchasing pool portion of the program. Purchasing credit members shall not be required to pay family contribution amounts greater than the cost to the applicant if the purchasing credit members were enrolled in the purchasing pool component of the program. When calculating the cost to the applicant to participate in the purchasing pool, the family contribution discounts provided in subdivisions (c), (d), and (e) of Section 12693.34 shall not be considered. Purchasing credit members shall be eligible for dental and vision coverage through the purchasing pool at no additional premium charge.~~

~~(b) The family contribution amounts paid on behalf of a purchasing credit member may be paid directly to the applicant's employer through a payroll deduction or other mechanism.~~

~~SEC. 28. Section 12693.45 of the Insurance Code is amended to read:~~

~~12693.45. (a) After 60 days of nonpayment of family contributions by an applicant, and a reasonable written notice period of no less than 30 days is provided to the applicant, subscribers or purchasing credit members may be disenrolled for an applicant's failure to pay family contributions and shall not be permitted to reenter the program for a period of six months. The department and the board may impose or contract for collection actions to collect unpaid family contributions.~~

~~(b) Disenrollments shall be effective as of the last period for which full family contributions were paid. The disenrollments may be retroactive.~~

~~(c) The department and the board may waive the period of exclusion in subdivision (a) if good cause is found, such as being laid off from employment or catastrophic illness.~~

~~SEC. 29. Section 12693.46 of the Insurance Code is repealed.~~

~~SEC. 30. Section 12693.48 of the Insurance Code is amended to read:~~

~~12693.48. The department and the board may adjust payments made to a participating health plan if the department and the board find that the plan has a significantly disproportionate share of high- or low-risk subscribers. Prior to making this finding, the program shall obtain validated data from participating health plans. Reporting requirements shall be administratively compatible with the methods of operation of the health plans. Any adjustments to payments shall utilize demographic and other factors which are actuarially related to risk.~~

~~SEC. 31. Section 12693.49 of the Insurance Code is amended to read:~~

~~12693.49. (a) When an applicant is dissatisfied with any action or inaction of a participating plan in which a subscriber is enrolled through the purchasing pool, the applicant shall first attempt to resolve the dispute with the participating plan according to its established policies and procedures.~~

~~(b) The department and the board shall assure that all participating health, dental, and vision plans make subscribers aware of the regulatory oversight available to the applicant by the participating health, dental, or vision plan's licensing or state oversight entity.~~

~~(c) The department and the board shall assure that all participating health, dental, and vision plans report to the department and the board, at least once a year, the number and types of benefit grievances filed by applicants on behalf of subscribers in the program. This information shall be available to applicants upon request in a format determined by the board.~~

~~SEC. 32. Section 12693.51 of the Insurance Code is amended to read:~~

~~12693.51. (a) A transfer of enrollment from one participating health plan to another may be made by a subscriber at times and under conditions as may be prescribed by regulations of the department and the board.~~

~~(b) The department and the board shall provide for the transfer of coverage of any subscriber to another participating plan (1) if a contract with any participating plan under which the subscriber receives coverage is canceled or not renewed and (2) at least once a year upon request in a manner as determined by the department and the board, and (3) if a subscriber moves to an area that the current health plan does not serve.~~

~~SEC. 33. Section 12693.52 of the Insurance Code is amended to read:~~

~~12693.52. The department and the board may negotiate or arrange for stop-loss insurance coverage that limits the program's fiscal responsibility for the total costs of health services provided to program subscribers, or arrange for participating health plans to share or assure the financial risk for a portion of the total cost of health care services to program subscribers, or both.~~

~~SEC. 34. Section 12693.53 of the Insurance Code is amended to read:~~

~~12693.53. The department and the board shall develop and utilize appropriate cost containment measures to maximize the coverage offered under the program. Those measures may include limiting the expenditure of state funds for this purpose of the price to the state for the lowest cost plan contracting with the program and creation of program rules that restrict the ability of employers or applicants to drop existing coverage in order to qualify families for the program.~~

~~SEC. 35. Section 12693.54 of the Insurance Code is amended to read:~~

~~12693.54. A contract entered pursuant to this part shall be exempt from any provision of law relating to competitive bidding, and shall be exempt from the review or approval of any division of the Department of General Services. The department and the board shall not be required to specify the amounts encumbered for each contract, but may allocate funds to each contract based on the projected or actual subscriber enrollments to a total amount not to exceed the amount appropriate for the program including family contributions.~~

~~SEC. 36. Section 12693.60 of the Insurance Code is amended to read:~~

~~12693.60. Coverage provided to subscribers shall meet the federal coverage requirements in Title XIX and Section 2103 of Title XXI of the Social Security Act and be consistent with the benefits under the program established pursuant to Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.~~

~~SEC. 37. Section 12693.61 of the Insurance Code is amended to read:~~

~~12693.61. The following provisions apply for subscribers who have been identified by the participating health plans as potentially seriously emotionally disturbed.~~

~~(a) Participating plans, to the extent feasible, including plans receiving purchasing credits shall develop memoranda of understanding, consistent with criteria established by the department and the board in consultation with the State Department of Mental Health, for referral of subscribers who are seriously emotionally disturbed to a county mental health department. This referral does not relieve a participating plan from providing the mental health coverage specified in its contract, including assessment of, and development of, a treatment plan for serious emotional disturbance. Plans may contract with county mental health departments to provide for all, or a portion of, the services provided under the program's mental health benefit.~~

~~(b) The department and the board shall establish an accounting process under which counties providing services to subscribers who have been determined to be seriously emotionally disturbed pursuant to Section 5600.3 of the Welfare and Institutions Code can claim federal reimbursement for the services. The department and the board shall reimburse counties pursuant to the rates set by the State Department of Mental Health in accordance with Sections 5705, 5716, 5718, 5720, 5724, and 5778 of the Welfare and Institutions Code. The actual~~

~~amount reimbursed by the board shall be the federal share of the cost of the subscriber.~~

~~(c) This section shall only become operative with federal approval of the State Child Health Plan and the approval of federal financial participation.~~

~~(d) Counties choosing to enter into a memorandum of understanding pursuant to subdivision (a) shall provide the nonfederal share of cost for the subscriber.~~

~~SEC. 38. Section 12693.615 of the Insurance Code is amended to read:~~

~~12693.615. (a) The department and the board shall establish the required subscriber copayment levels for specific benefits consistent with the limitations of Title XIX and Section 2103 of Title XXI of the Social Security Act. Total annual health, vision, and dental copayments charged to subscribers shall not exceed two hundred fifty dollars ($250) per family. The department and the board shall instruct participating health plans to work with their provider networks to provide for extended payment plans for subscribers utilizing a significant number of health services for which copayments are charged. The department and the board shall track the number of subscribers who meet the copayment maximum in each year and make adjustments in the amount if a significant number of subscribers reach the copayment maximum.~~

~~(b) No deductibles shall be charged to subscribers for health benefits.~~

~~(c) Coverage provided to subscribers shall not contain any preexisting condition exclusion requirements.~~

~~(d) No participating health, dental, or vision plan shall exclude any subscriber on the basis of any actual or expected health condition or claims experience of that subscriber or a member of that subscriber's family.~~

~~(e) There shall be no variations in rates charged to subscribers including premiums and copayments, on the basis of any actual or expected health condition or claims experience of any subscriber or subscriber's family member. The only variation in rates charged to subscribers, including copayments and premiums, that~~

~~shall be permitted is that which is expressly authorized by Section 12693.43.~~

~~(f) There shall be no copayments for preventive services as defined in Section 1367.35 of the Health and Safety Code.~~

~~(g) There shall be no annual or lifetime benefit maximums in any of the coverage provided under the program.~~

~~(h) Plans that receive purchasing credits pursuant to Section 12693.39 shall comply with subdivisions (b), (c), (d), (e), (f), and (g).~~

~~SEC. 39. Chapter 6 (commencing with Section 12693.63) of Part 6.2 of Division 2 of the Insurance Code is repealed.~~

~~SEC. 40. Chapter 7 (commencing with Section 12693.65) of Part 6.2 of Division 2 of the Insurance Code is repealed.~~

~~SEC. 41. Section 12693.68 of the Insurance Code is amended to read:~~

~~12693.68. The department and the board shall encourage all plans, including those receiving purchasing credits, that provide services under the program to have viable protocols for screening and referring children needing supplemental services outside of the scope of the screening, preventive, and medically necessary and therapeutic services covered by the contract to public programs providing such supplemental services for which they may be eligible, as well as for coordination of care between the plan and the public programs. The public programs for which plans may be required to develop screening, referral, and care coordination protocols may include the California Children's Services Program, the regional centers, county mental health programs, programs administered by the Department of Alcohol and Drug Programs, and programs administered by local education agencies.~~

~~SEC. 42. Section 12693.75 of the Insurance Code is amended to read:~~

~~12693.75. (a) The department and the board shall create and implement a simplified application package,~~

~~and shall seek input from the board, consumers, advocates, providers, and other interested parties in the development of the application.~~

~~(b) The simple application may be mailed in and processed through an independent entity by agreement with the department, or through the county. Eligibility shall be presumed for a specified time period after an initial screening by the independent entity or county. The department or county shall make the final determination of eligibility. Under no circumstances shall eligibility determinations take longer than 45 days.~~

~~(c) To the extent permitted by federal law, a child or family who is enrolled in any of the following programs shall be eligible for this program:~~

SECTION 1. Section 12693.755 is added to the Insurance Code, to read:

12693.755. (a) Any child who is enrolled in any of the following programs shall be deemed to have met the income eligibility requirements for participation in the Healthy Families Program and the Medi-Cal program:

(1) The Food Stamp Program, provided for pursuant to Chapter 10 (commencing with Section 18900) of Part 6 of Division 9 of the Welfare and Institutions Code.

(2) The California Special Supplemental Food Program for Women, Infants, and Children, provided for pursuant to Article 2 (commencing with Section 123275) of Chapter 1 of Part 2 of Division 106 of the Health and Safety Code.

(3) The federal Head Start program, provided for pursuant to Subchapter 2 (commencing with Section 9831) of Chapter 105 of Title 42 of the United States Code.

(4) The federal School Lunch programs, provided for pursuant to Chapter 13 (commencing with Section 1751) of Title 42 of the United States Code.

~~(d) The programs specified in subdivision (c) shall forward relevant information, with the consent of the applicant, to this program for purposes of establishing program eligibility.~~

~~SEC. 43. Sections 1 to 42, inclusive, of this act shall be inoperative in any fiscal year in which funds have not~~

~~been specifically designated in the Budget Act for that fiscal year for implementation of this act.~~

(b) Agencies administering programs specified in subdivision (a), the State Department of Health Services, and the board shall implement streamlined processes for establishing eligibility of a child enrolled, or applying for participation, in the Healthy Families Program or the Medi-Cal program, and shall not require the child to provide any unnecessary or duplicative information. The State Department of Health Services shall be the lead agency in charge of this effort.

(c) Agencies administering the Healthy Families Program and the Medi-Cal program shall fully cooperate in distributing information and providing enrollment information to the State Department of Health Services and the board or their designees, to the maximum extent permitted by federal and state law.

(d) Enrollment information shall be used by the State Department of Health Services and the board or their designees for the sole purpose of determining a child's eligibility for benefits under the Healthy Families Program or the Medi-Cal program.

(e) The State Department of Health Services and the board shall implement subdivisions (a) to (d), inclusive, by not later than July 1, 2001.

(f) The State Department of Health Services shall assess what other public programs the eligibility for which may be used to meet income eligibility requirements for the Healthy Families Program and the Medi-Cal program, shall develop a plan for utilizing those requirements in determining eligibility for the Healthy Families Program and the Medi-Cal program, and shall submit the plan to the appropriate fiscal and policy committees of the Legislature.

(g) This section shall not be implemented in any fiscal year in which funds have not been specifically designated in the Budget Act for that fiscal year for the implementation of this section.

SEC. 2. Section 14011.15 of the Welfare and Institutions Code is amended to read:

14011.15. (a) The department shall, not later than July 1, 2000, create and implement a simplified application package for children, families, and adults applying for Medi-Cal benefits. This simplified application package shall include a simplified supplemental resource form.

(b) In developing the application package described in subdivision (a), the department shall seek input from persons with expertise, including beneficiary representatives, counties, and beneficiaries.

(c) The department shall allow an applicant to apply for benefits by mailing in the simplified application package.

(d) The simplified application package shall utilize at a minimum, all of the following documentation standards:

(1) Proof of income shall be documented by the most recent paystub or a copy of the last year's federal income tax return.

(2) Self-declaration of pregnancy.

(3) A simplified supplemental resource form, if applicable.

(e) The department shall not require an applicant who submits a simplified application pursuant to this section to complete a face-to-face interview, except for good cause, a suspicion of fraud, or in order to complete the application process. A county shall conduct random monitoring of the mail-in application process to ensure appropriate enrollment. Every application package shall contain a notification of the applicant's right to complete a face-to-face interview.

(f) ~~Not later than July 1, 2000,~~ *Commencing January 1, 2001,* the department shall ~~revise the quarterly reporting form to be as simple as possible to complete~~ *eliminate quarterly status reports*.

(g) The department shall implement this section only to the extent that its provisions are not in violation of the requirements of federal law, and only to the extent that federal financial participation is not jeopardized.

(h) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the

Government Code, the department shall implement this section by means of an all county letter or similar instruction without taking regulatory action. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 3. Section 14012 of the Welfare and Institutions Code is amended to read:

14012. Reaffirmation shall be filed annually~~ and may be required at other times in accordance with general standards established by the department~~.

SEC. 4. Notwithstanding Section 17610 of the Government Code, if the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code. If the statewide cost of the claim for reimbursement does not exceed one million dollars ($1,000,000), reimbursement shall be made from the State Mandates Claims Fund.

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